The incidence of type 1 diabetes in Latino children of Puerto Rican origin is higher than that previously thought. For instance, the incidence rate among Puerto Ricans in Philadelphia (1990–1994) was 15.5/100,000 compared with 12.8/100,000 for Caucasians (Lipman et al., 2006; Lipman, Chang, & Murphy, 2002). Moreover, the incidence rate for Puerto Rican children in Philadelphia was the highest incidence rate of any racial group in the United States (Lipman et al., 2006). The incidence rate may be even higher for Latino boys. In Chicago, the U.S. city with the third largest Latino population, the incidence rate of type 1 diabetes in Latino boys increased from 7.2/100,000 (1985–1990) to 10.5/100,000 (1990–1994), with no change over 10 years for Latino girls (8.4/100,000; Lipton, Keenan, Onyemere, & Freels, 2002).

Latino children may also be at greater risk of complications associated with chronic illness due to language barriers, limited health insurance coverage, and cultural beliefs about illness (Flores et al., 2002; Hendricson et al., 1996). Young Latino children with type 1 diabetes have more frequent hospitalizations and higher mortality than those of Caucasian children and may have coexisting conditions such as asthma (Lipton, 1996; Lipton, Good, Mikhailov, Freels, & Donoghue, 1999). These situations can be very stressful for parents of any ethnicity, but language barriers may further isolate Latino families from both illness-specific social support and medical care (Wu, Leventhal, Ortiz, Gonzalez, & Forsyth, 2006).

When a child is newly diagnosed with type 1 diabetes, parents must quickly learn to provide complex illness management which requires a combination of critical thinking skills and a thorough understanding of diabetes-related pathophysiology (Sullivan-Bolyai, Deatrick, Gruppuso, Tamborlane, & Grey, 2003). For example, management involves checking blood glucose levels, deciphering how much insulin is needed, monitoring carbohydrate intake, planning meals, differentiating between normal child development responses and behaviors related to changes in glucose level, and negotiating the child’s school and socialization activities within the context of type 1 diabetes. Parents must incorporate complex diabetes-related care into their daily life along with all their other family-related activities and responsibilities. In the face of such day-to-day management demands, mothers have reported feelings of isolation, stress, and anxiety after the initial diagnosis and that social supports were limited...
(Sullivan-Bolyai et al., 2003). Another challenge for mothers has been identifying qualified babysitters willing and capable of watching their children for short periods, so mothers can run errands, take respite, or enjoy time away with their spouses (Sullivan-Bolyai, Deatrick, Gruppuso, Tamborlane, & Grey, 2002). To better attend to the day-to-day management of their child’s diabetes, many of these mothers also reported not working or quitting their jobs once their child was diagnosed. School issues for those attending day care or preschool were also difficult, especially with the staff not being familiar or qualified to care for a child with type 1 diabetes. This situation resulted in many mothers avoiding the risk of inadequate diabetes care by choosing not to place their child in preschool or day care (Sullivan-Bolyai et al., 2002).

These findings indicated a need for social support among parents of young children (1–12 years old) newly diagnosed with type 1 diabetes. As a first step to providing that support, a postdiagnosis mother–mother mentoring intervention was adapted (Sullivan-Bolyai et al., 2004) from a parent–network intervention (Ireys, Chernoff, Stein, DeVet, & Silver, 2001). The overall goals of the intervention were to provide this population of mothers with three types of support: informational, affirmational, and emotional. Examples of informational support included ways of how to prepare school staff to care for their child with diabetes, ways of how to identify useful community resources, and tips for traveling with these children. Affirmational support included having one’s feelings and experiences confirmed by other mothers of children with diabetes. Emotional support included active listening during times of crisis or stressful situations such as post-clinical visits or episodes of hypoglycemia. This intervention was tested for feasibility in a randomized control trial with mothers of young children newly diagnosed with type 1 diabetes (Sullivan-Bolyai et al., 2004).

The mothers received social support shortly after their child’s diagnosis (see Table 1 for an overview of the intervention) from trained parent mentors (mothers who were successfully managing their young child’s type 1 diabetes; see Table 2 for an overview of the training curriculum). Parent mentors provided support consisting of face-to-face visits and telephone calls over the course of 6 months and were paid an hourly wage for their services and expertise. Mothers who received the intervention had fewer concerns, more confidence, identified more resources, and described the disease as less negatively affecting their family than did mothers who did not receive parent-mentor support. The postdiagnosis needs of fathers of these children were then explored (Sullivan-Bolyai et al., 2006) and incorporated into a randomized controlled trial currently in progress to support parents of young children newly diagnosed with type 1 diabetes, the Social Support to Empower Parents (STEP) intervention (National Institute of Nursing Research, National Institutes of Health Grant R15 NR008391).

### SOCIAL SUPPORT TO EMPOWER PARENTS INTERVENTION

The STEP program is based on a conceptual framework in which social support can directly affect the mental health of parents raising children with a chronic condition (Ireys, Chernoff, DeVet, & Kim, 2001). Parental mental health may also shape the family environment, which can then influence the child’s adjustment. Thus, the author hypothesized
that enhancing parental social support would decrease parental concern, worry, distress, and strain; increase parental confidence; and decrease the perceived impact of diabetes on the family. To test this hypothesis, the STEP intervention is presently being offered to both mothers and fathers of children newly diagnosed with type 1 diabetes.

The parent-mentor curriculum covers core topics (Table 3) that help parents with newly diagnosed children adjust to the day-to-day diabetes management, deal with common diabetes-related family issues, and learn creative ways to encourage their children with type 1 diabetes to eat recommended meals. Meal recommendations include tips on carbohydrate portions, issues with picky eating, and ways of how to plan/manage meals and snacks during the holidays. The curriculum also reviews the 504 school plan (Section 504 of the Rehabilitation Act and the Americans with Disabilities Act), which ensures that individuals with a disability or chronic condition will not be excluded from any federally funded programs (Lawlor, 2004).

### Table 3. Core Topics of Parent-to-Parent Discussions

<table>
<thead>
<tr>
<th>Core topic</th>
</tr>
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<tbody>
<tr>
<td>Helping the child with diabetes to grow and develop</td>
</tr>
<tr>
<td>Parental day-to-day responsibilities in managing diabetes</td>
</tr>
<tr>
<td>Sibling issues</td>
</tr>
<tr>
<td>Behavior/Discipline issues</td>
</tr>
<tr>
<td>Dealing with doctors, nurses, and the medical system</td>
</tr>
<tr>
<td>Dealing with specific day care- or school-related issues</td>
</tr>
<tr>
<td>Out-of-school activities such as babysitting, camps, and parties</td>
</tr>
</tbody>
</table>

The author searched the empirical literature for diabetes-specific Latino family interventions that might be incorporated into the STEP intervention to specifically address the day-to-day issues of managing type 1 diabetes or to support Latino parents after their child’s diagnosis. No such interventions were found. However, an important Latino support concept that emerged was *familism*, “a cultural value including interdependence among nuclear and extended family members for support, loyalty, and solidarity” (Magana, 1999, p. 467). In times of crisis, such as when a family member is diagnosed with a chronic illness, Latino family members come together to provide support (emotional and informational); advice; and when necessary, respite for primary caregivers (Fisher et al., 2000). Thus, it was not clear if support offered to Latino parents by an unfamiliar person would be well received or effective.

Little is known about the kinds of support sought by Latino families as they adapt to managing their child’s type 1 diabetes. Latino family members have been reported to use few informal social support networks outside the family (Flores et al., 2002). In addition, families from diverse cultures may differ in how they process disease management information (Chesla & Rungreangkulki, 2001; Flakerud et al., 2002). Thus, it is critical for the STEP curriculum to be reviewed and assessed for cultural relevance by parents of young children with type 1 diabetes who are living in the targeted Latino community. Therefore, the overall goal of this study was to culturally and linguistically adapt the parent-mentor training curriculum of the STEP intervention for Latino families with young children with type 1 diabetes. The specific aims were to describe Latino parents’ experience after their child’s diagnosis and to review the cultural and linguistic sensitivity of the STEP parent-mentor curriculum. The curriculum review determined which components could stay the same, which needed to be altered, and what components could be added to improve parent mentors’ illness-specific social support to Latino families.

### METHODS

#### Study Design

This study used a descriptive, participatory action research (PAR) design. PAR is a research process developed in collaboration between academic researchers and community members from...
the ground up within a community to improve social conditions or clinical outcomes (Olshansky et al., 2005). The strength of PAR is that community members work with researchers to identify and create interventions or education programs. The power balance is shifted from researchers to participants, resulting in colearning. PAR involves an iterative and cyclical process of planning, acting, developing, and reflecting to better understand the targeted community, form partnerships, identify and address barriers, and create change (Cawston, Mercer, & Barbour, 2007; Olshansky et al., 2005).

PAR can be especially helpful when working with minority and/or marginalized groups (Schwartz, Sable, Dannerbeck, & Campbell, 2007).

An essential element of PAR is working with key informants within the community to better understand the targeted experiences, that is, parents caring for young children newly diagnosed with type 1 diabetes. Before conducting this study, four key informants from the Latino community, three mothers and one father of children with diabetes, were informally interviewed to discuss the feasibility of culturally adapting the STEP curriculum. The response was very encouraging. In fact, the father suggested culturally adapting a Latino version of STEP, entitled *Familias Apoyadas Por Una Misma Causa* (families supporting each other for a common cause).

It is important to note that the design originally planned for this formative work was a focus group approach. However, significant problems were encountered scheduling parents to attend a group session. They had unexpected family obligations (children who were sick, grandparents that needed attention, and extra work shifts that became available) that prevented a mutual time to meet. Therefore, we chose to conduct individual interviews using qualitative description.

For the formal interviews in this study, a qualitative descriptive approach (Sandelowski, 2000; Sullivan-Bolyai, Bova, & Harper, 2005) was used to provide easily understood descriptions of Latino parents’ perceptions of the STEP training curriculum. Qualitative description provides a lower degree of inference than that of other qualitative designs, facilitating adoption of the participants’ comments and recommendations for making the original STEP curriculum culturally relevant to Latinos. Thus, data were collected during in-depth one-on-one interviews with four purposively selected Puerto Rican-origin Latino mothers who had at least one child diagnosed with type 1 diabetes. These data were checked against data gathered from the four key informants.

**Participants**

Latino mothers of children with type 1 diabetes who resided in the local Latino community were contacted by the researcher about participating in individual interviews. These mothers had been informed about the STEP intervention. Fathers were approached but were unavailable due to work demands. Four mothers, all bilingual and with excellent command of English, agreed to participate. Of these four mothers, two chose to be interviewed face to face, and two chose telephone interviews. They were of middle age (38–42 years), employed full-time, and well educated (all were high school graduates, and one mother had attended college). One mother had two children with type 1 diabetes. The children were all boys, 7 to 12 years old, and had been diagnosed 1 to 5 years earlier.

**Procedure**

The study was approved by the institutional review board at the University of Massachusetts, Worcester. After obtaining informed consent from each mother, the researcher conducted open-ended interviews either in a private room at the medical center or by telephone. All interviews lasted 60 to 90 minutes. Interviews were guided by the STEP training curriculum for parent mentors (Table 2), which was reviewed along with the role of the parent mentor. Probe questions were used to encourage participants to specify how each curriculum component might be made more culturally sensitive. Thus, participants were asked to recommend whether each component could stay the same, needed adaptation to improve its cultural sensitivity, or needed additional components or information to enhance mentor–parent interactions. Interviews were audiotaped and documented as field notes. Each mother received $20 for participating.

**Data Analysis**

Transcripts from the interviews and field notes were organized in a matrix (Miles & Huberman, 1994). This matrix was framed by each component of the STEP curriculum and each participant’s recommendations: do not change the component, adapt component to improve cultural sensitivity, or add components/information. After incorporating the recommendations of the first participant, the matrix was extended to incorporate additional information from the other three participants.
Trustworthiness

Credibility of the recommendations was supported by reviewing the findings through member checks with all four participants (Lincoln & Guba, 1985), who verified that the findings clearly represented their recommendations. The dependability of the study was increased by having only one interviewer who was familiar with the curriculum and intervention.

RESULTS

Latino Parents' Experience After Their Child's Diagnosis

The participants described their initial experience of finding out that their child had type 1 diabetes as feeling stressed, anxious, and overwhelmed by the amount of information they had to learn to care for their child’s diabetes. They had limited access to diabetes-specific social support resources. School issues identified included difficulty with finding school staff willing and able to help manage the child’s disease, limited day care and babysitting resources. Another problem identified was the lack of access to bilingual health care providers who understood cultural issues related to nutrition. All four Latino mothers supported the concept of adapting the STEP curriculum for Latino families (consistent with the key informant interviews).

Social Support to Empower Parents Goals and Guidelines; Training Goals

All four mothers agreed that the title, Familias Apoyadas, captured the intent of the program for Latino families. They also recommended keeping the title, as it was suggested by a Latino parent, and keeping it reflected respect for their opinions. Three mothers also pointed out that serving as a parent mentor might create an additional source of income for families. Another issue discussed about parent mentors was finding the time to connect with families, especially when parent mentors were working. The mothers believed that the very careful process of selecting parent mentors would eliminate those unable to reach out and help. They concurred that weekends and after work were reasonable times for mentors to visit or make their telephone calls. They stated that reaching out and helping others in their community were positive spiritual activities for all involved. They shared that working as parent mentors might also help decrease some of the depression or sadness they all experienced after their children were diagnosed with diabetes. The issue of sustainability was broached (in light of the difficulties in setting up focus groups), but all mothers were very enthusiastic and felt that such a program would be well received and utilized over time.

The participants emphasized the importance of the parent mentors being bilingual because some Latino parents may have a language barrier that inhibits or limits their calls to health care providers and access to clinics. The participants also stressed that parent mentors should speak a dialect similar to that of the family to which they are assigned, thus enhancing communication. Thus, other than addressing language barriers, the participants recommended keeping the goals and guidelines the same in the adapted training curriculum.

Communication Principles and Strategies for Working With Families

All four mothers acknowledged the importance of parent mentors using active listening and approaching new families with a nonthreatening tone to assure them that their feelings were normal and very similar to the mentor’s own feelings when their child was newly diagnosed. Mentors who came across as “too expert” might pose problems by intimidating parents. The participants suggested that parent mentors should be trained to discern when sharing their own experiences would and would not be appropriate. Thus, they recommended not changing but underscoring the training section that dealt with when and when not to share experiences.

Core and Other Family-Related Topics

All mothers agreed that the seven core topics (Table 3) were important issues for parent mentors to discuss with their assigned family. They also suggested that parent mentors could occasionally accompany their assigned families to the clinic to help translate and later review and reinforce the topics discussed during the clinic visit. The participants also suggested translating into Spanish all handouts used for teaching parents of children newly diagnosed with diabetes but offering the handouts in both English and Spanish because other family members might be more comfortable in one language over another.

Another core topic singled out for emphasis was discussing normal developmental issues related to sharing diabetes management with the child, for example, knowing what age to let a child help with glucose checks, giving insulin, and helping determine what he or she can eat. Similarly, participants...
suggested providing parent mentors with a handout on shared diabetes management for review with new parents. Thus, the participants recommended keeping the core topics but adding a handout with guidelines for developmental milestones to help parents assess when it might be appropriate to allow their child to be more involved in his or her diabetes management.

Family and Sibling-Strain Issues

Family issues or topics that the participants identified as especially important to review with parent mentors included parent–child and spousal relationships; the adjustment to diabetes of the child with diabetes and siblings; and general family problems such as food restrictions, sleep deprivation, and time for day-to-day management of diabetes. The mothers felt that parent mentors who had also experienced and solved many of these psychosocial strains could help other families deal with similar situations by sharing their experiences. The participants noted that many Latino mothers would be the primary caregivers of their child with diabetes and would greatly benefit from talking one on one with another mother experienced with the disease. They all voiced feeling sad and overwhelmed after their child was diagnosed and that they would have appreciated talking to another parent who had felt the same way, thus affirming that their reaction was normal.

They stressed the importance of encouraging fathers to participate in the day-to-day hands-on management of their child’s diabetes. They suggested that parent mentors reinforce the importance of fathers’ participation by role playing likely scenarios such as emergencies when the mother cannot provide usual care. This involvement by fathers might decrease some of the maternal stress associated with day-to-day management of diabetes. They also shared that fathers should be encouraged to spend one-on-one time with the other children at home, freeing mothers to attend to some of her own needs.

During the discussion about family issues, participants shared that their communities lacked qualified babysitting services for their children with diabetes. The participants discussed the possibilities of offering diabetes training for babysitters or developing a cooperative association of parents who have children with type 1 diabetes to babysit for each other’s children. Thus, the participants suggested not only keeping the family-strain information as is but also exploring alternative babysitting strategies, including educational options. Two mothers shared concerns about potential liability issues related to the babysitters’ responsibilities. For example, if a babysitter did not correctly manage a medical emergency, he or she might be legally liable for any harm to the child with diabetes.

Setting Boundaries

The mothers agreed that parent mentors could potentially create problems by not clarifying the boundaries of their involvement with their mentee families. They liked the idea that potential issues could be solved in the STEP program by the parent-mentor coordinator or principal investigator who would always be available to help solve such issues if they arose. They also supported this supervision system as a reporting structure if the parent mentors saw any signs of abuse, neglect, or depression among their assigned families. No changes were recommended.

Parent/Family Educational Materials and Resources

Among the topics covered in educational materials, the participants were greatly interested in cultural food preparation and nutritional concerns. The participants did not suggest any changes in the written curriculum materials but suggested adding experiential ways to educate Latino parents on this topic. For example, they suggested offering weekend cooking classes to all family members to encourage their involvement in care. At the same session, the parent mentor and a nutritionist could review carbohydrate counting and provide basic education on type 1 diabetes to interested family members. Such teaching might be a way to help other family members feel more comfortable with helping to manage diabetes, thus providing additional babysitting support for mothers. Another suggestion to facilitate healthy eating was to provide a list of translated recipes for traditional meals with specific information on carbohydrate portions.

Another handout for parents (the 504 school plan) is explained by the STEP parent mentors, but participants felt that the concepts, child’s rights, and parent advocacy role are complicated and might need clarification. The participants also stressed the importance of reviewing how to effectively work with the day care staff and/or school nurses. This topic was identified by these experienced parents as critical, especially for older children with type 1 diabetes. They also agreed that providing information about local camps was important, especially scholarship options because some camps are costly.
An important resource discussed for parents of newly diagnosed children was community resources. Transportation to clinic appointments was seen as an access barrier for some families, especially for those who spoke English as a second language. One creative parent suggested identifying a local taxi company with bilingual drivers to address the transportation issue. As mentioned earlier, parent mentors might occasionally accompany parents to clinic visits and later reinforce diabetes information and education that had been provided by the health care professionals. The participants reported being so overwhelmed with some clinic visits that they missed or forgot some important information.

All four parents shared that weekend or evening clinics would be very helpful because many Latino parents work during normal clinic hours. Leaving work early for clinic always meant loss of income. In addition, daytime weekday clinics resulted in missed school time for children. Among this small group of parents, flexible clinic hours were not available.

The participants were also receptive to parent mentors helping parents of newly diagnosed children to better understand their child’s developmental abilities, with expectations about tasks related to diabetes management. As described earlier, participants liked the idea of having written materials on developmental milestones (motor, psychosocial, and emotional) to help parents judge when to involve their child in diabetes management tasks. This issue, which is typically discussed during clinic visits, could also be reinforced in the home with a parent mentor’s guidance.

Paperwork and Supervision

The participants recommended no changes in the parent mentors’ paperwork associated with their family contacts, for example, topics discussed, type of contact (face-to-face visit, telephone call, and e-mail), length of contact, and the ease/difficulty of the contact interaction(s). The mothers found the paperwork easy to understand, efficient, and easy to fill out.

DISCUSSION

In general, the participants agreed with all the STEP curriculum components. However, they recommended adding information to enhance and address some cultural issues that Latino parents face, such as the language barrier with health care providers and how to adapt traditional Latino menus. Many recommendations for families with a child newly diagnosed with diabetes, for example, bilingual educational handouts, guidelines for developmental milestones, clarification on the 504 education plan, evening and weekend clinic access, and identification of taxi services with bilingual drivers, underscore the importance of nurses working with these families to individualize discharge planning materials. In some instances, the changes can easily be made and can facilitate the management of these children. For instance, we have located a taxi company with bilingual drivers and providing service to the catchment area where most of our Latino families reside. The suggestion for evening and weekend clinic hours has also been passed to the diabetes team staff members for their consideration.

Many of the concerns and needs expressed by the Latino mothers in this study mirrored those of non-Latino parents of young children with type 1 diabetes (Sullivan-Bolyai et al., 2003) and of Latino parent informants in preliminary interviews. However, this study’s participants were the only mothers of children with diabetes among the author’s several studies on this population to suggest evening or weekend access to a clinic. This difference was likely due to the Latino mothers in this study not only managing their child’s diabetes with limited support but also working outside the home. In contrast, other mothers reported having to quit their jobs or working part-time to manage their child’s diabetes after diagnosis (Sullivan-Bolyai et al., 2002).

In fact, this overburden among the participants due to daily family and child-rearing responsibilities, along with out-of-home work commitments, may have accounted for the difficulty in this group of mothers finding time to meet and discuss these issues in a focus group. This phenomenon, which is not unique to Latino women, has been referred to as “work–family or family–work spillover” (Long Dilworth & Kingsbury, 2005; Roehling, Hernandez, & Swope, 2005). Negative work–family spillover has been associated with physical health decline; mental health issues such as depression, stress, and anxiety; and marital strain and diminished relationship quality (Long Dilworth & Kingsbury, 2005; Roehling et al., 2005). However, the effects of additional parental demands associated with diabetes management on work–family spillover have not been addressed. The concept of work–family spillover...
begs for further clarification in families of children with special health care needs. Parental work obligations and family responsibilities should always be part of the nursing discharge plan assessment to determine the need for additional community resources.

Within the Latino community, many couples have egalitarian relationships, but part of the spillover issue may be related to different cultural role expectations and traditional gender–role beliefs such as the concept of marianismo (D’Alonzo, 2007). Marianismo, which is the feminine counterpart of machismo, is typified by self-sacrifice and putting family and child-rearing responsibilities over one’s own needs. On the other hand, both marianismo and machismo contribute to the strong Latino values of family cohesiveness and support (Kilinski, 2006). These factors may account for Latino mothers experiencing higher levels of negative family–work spillover when they work outside the home and for their having more responsibility for the bulk of child, family, and home responsibilities than do Latino fathers or White and African American mothers and fathers (Roehling et al., 2005). Another explanation for these differences may be that Latino women are newer to the United States and the American workforce because a greater proportion of Latinos (39%) than non-Latinos (3%) are born outside the United States (Roehling et al., 2005). Latino women also lack a working cultural template, which has become the norm among most American culture, for juggling work, family, and personal responsibilities (Roehling et al., 2005). These conflicting demands might explain the participants’ positive reception of the focus group and their difficulty in meeting their commitment.

Although little attention has been paid to fathers’ involvement in the disease management of children with type 1 diabetes (Dashiff, Morrison, & Rowe, 2008), fathers have reported the importance of seeking opportunities to hone their management skills to help relieve their spouses’ burden of care (Sullivan-Bolyai, Rosenberg, & Bayard, 2006). One strategy for encouraging the involvement of Latino fathers would be for parent mentors to link this involvement to the positive aspects of machismo, for example, protecting the family by protecting their child from the long-term complications of diabetes (Galanti, 2003). Another strategy would be for parent mentors to discuss with fathers how helping with diabetes care could help protect mothers from stress, anxiety and depression associated with the burden of child care; disease management; and family, home, and work responsibilities. In general, nurses should assess the division of labor regarding diabetes management responsibilities and include fathers in teaching plans.

As the United States population has become more diverse, language barriers have become a common issue in health care access. Language barriers in health care settings result in less satisfaction, decreased clinic follow-up appointments, less compliance with prescribed treatments, and poor understanding of adverse side effects with prescribed drugs (Wu et al., 2006). The suggestion that parent mentors accompany the family to clinic visits for translation and support is an important one, although confidentiality issues would need to be investigated (Karliner, Jacobs, Chen, & Mutha, 2006). Having an invested parent mentor who works with the family in the home may lead to greater health care delivery satisfaction, trust, and adherence to prescribed treatments plans. During clinic interactions with a parent mentor present, health care providers would also have an opportunity to enhance their understanding of the family’s cultural health beliefs and behaviors.

The participants’ recommendation for review and additional diabetes management information could be satisfied by a health care provider-generated diabetes information checklist for parent mentors. The information covered in the clinic could then be discussed and reviewed during home visits or telephone calls. In addition, having educational and informational handouts in both Spanish and English would clarify some words that may not be easily translated; thus, parents could read both versions to facilitate the learning process. Parent mentors could communicate to providers how the review was received, thus clarifying any information that needed reinforcement during the next clinic visit. Repeated review would likely enhance internalization of diabetes management knowledge. Identifying other family members and/or friends to learn about managing diabetes care might provide mothers with additional physical and social support.

Diabetes management topics suggested by the participants (such as diabetes camp resources, how to best work with school nurses, and when to begin sharing disease management with the child) have been shown to help build parents’ confidence in managing the day-to-day tasks
associated with diabetes care (Ginsburg et al., 2005; Murphy, Rayman, & Skinner, 2006). In addition, better access to clinic resources, for example, by transportation with bilingual taxi drivers or by weekend and evening hours that better serve children with special needs during school hours and working parents, may also improve clinical outcomes.

Limitations

The results of this study are limited by the small number of participants, by only mothers of male children as participants, by all participants being of Puerto Rican origin, and by all being highly acculturated (with excellent command of the English language) and well educated. These limitations may have restricted the perspectives of their recommendations. Thus, future studies will review the recommendations with a larger sample, including parents from other Latino countries, who are less acculturated to the United States, less educated, and are raising girls with type 1 diabetes as well. However, it is important to note that there are more Latino boys diagnosed than girls (Lipman et al., 2006). In addition, the lack of generalizability with this small well-educated sample of mothers cautions the researcher to avoid overinterpreting the results for nursing implications. The results do, however, provide some very concrete ways to adapt the present STEP parent-mentor training curriculum to better serve Latino families. According to PAR principles, the STEP curriculum will be further tested and adapted among members of the target community.

Another limitation was changing the planned qualitative approach from focus group to individual interviews. Focus groups may have enhanced the social interaction among the participants, resulting in findings with a greater social context. However, individual interviews were the next best thing and provided some very creative and innovative ideas that can be easily incorporated into Familias Apoyadas or other Latino-focused parent interventions. Face-to-face versus telephone interviews may also have affected disclosure, although all mothers were very engaged in conversation and enthusiastic to participate, regardless of interview mode. Although one interview mode would have been methodologically cleaner, the researcher opted for flexibility (in keeping with PAR) to accommodate the participants. Home interviews (offered to each of the participants) may have been too threatening for some when given the choice.

Unfortunately, no fathers were involved in the study due to work obligations. The key informant father who named the Latino version of the STEP was very helpful and insightful. For instance, he felt that fathers would be interested in participating unless they were too macho. He also clarified that machismo does not necessarily indicate a negative attribute, as sometimes interpreted; it can mean being protective of and wanting the best for your loved ones. He also said he would have readily embraced such a program if it had been offered to him. In future studies, both fathers and mothers will be actively recruited as parent mentors. The feasibility of fathers participating as parent mentors will be one aim for testing the intervention in ongoing exploratory PAR in the Latino community.

Conclusions

The interview data suggest that parents of young children newly diagnosed with type 1 diabetes share many needs and concerns, regardless of culture. However, the data also suggest the importance of not assuming that one size fits all and the merit of adapting training curricula for behavioral interventions to provide culturally sensitive and relevant strategies. To better help Latino families adapt to the day-to-day management of their young children with type 1 diabetes, nurses should talk to parents about their specific needs. In addition, the issue of participants being unable to meet for a focus group may provide insight regarding cultural issues that might affect adherence to clinic appointments, teaching sessions before inpatient discharge, or research designs.

The study findings underscore the importance for nurses to frame parental education and social support needs within the cultural context of Latino families. Although the participants strongly supported offering parent-mentor support and stressed the importance of community support despite personal responsibilities and commitments, it remains to be seen if Latino parent mentors can be easily identified, trained, and have the time to follow families with a child newly diagnosed with diabetes. Reaching out to these families is crucial for improving clinical outcomes, but further exploration is needed on the feasibility of providing culturally sensitive supplemental support. The STEP intervention is currently pilot testing the Latino version training curriculum with a Latino female parent mentor.
Crafting interventions that reflect a cultural community’s values, beliefs, and commitments to others is vital to their success. To quote the community activist Edward James Olmos, “Take care of your family first. But then reach out to your neighbor, your block, your city, your country” (Learning To Give, n.d. p. 1). That said, the participants’ recommendations will be tested, closely examined again, and adapted to ensure that the Latino version of the STEP intervention represents illness-specific social support that might benefit Latino families raising young children with type 1 diabetes.

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